



# *School-Based Services*

*Medicaid and Other Medical  
Assistance Programs*



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December, 2003

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<b>My Medicaid Provider ID Number:</b>
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# Covered Services

## General Coverage Principles

Medicaid covers health-related services provided to children in a school setting when all of the following are met:

- The child qualifies for Individuals with Disabilities Education Act (IDEA)
- The services are written into an Individual Education Plan (IEP)
- The services are not free. Providers may not bill Medicaid for any services that are generally offered to all clients without charge.

This chapter provides covered services information that applies specifically to school-based services. School-based services providers must meet the Medicaid provider qualifications established by the state and have a provider agreement with the state. These providers must also meet the requirements specified in the *School-Based Services* manual and the *General Information For Providers* manual. School-based services provided to Medicaid clients include the following:

- Therapy services (physical therapy, occupational therapy, speech language pathology and audiology)
- Private duty nursing
- School psychology and mental health services (including clinical social work and clinical professional counseling)
- Comprehensive School and Community Treatment (CSCT)
- Personal care (provided by paraprofessionals)
- Other diagnostic, preventative and rehabilitative services

### ***Services for children (ARM 37.86.2201 – 2221)***

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all school-based services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply (see the *PASSPORT and Prior Authorization* chapter in this manual).

### ***Services within scope of practice (ARM 37.85.401)***

Services provided under the school-based services program are covered only when they are within the scope of the provider's license.

**Provider requirements**

Most school-based services must be provided by licensed health care providers. The exception is that activities of daily living services may be provided by personal care paraprofessionals. Medicaid does not cover services provided by a teacher or teacher's aide; however, teachers or teacher aides may be used to assist in the development of child care planning. School-based services must be provided by only those providers listed in the table below.

Provider Type	Provider Requirements
Private duty nursing services provided by: <ul style="list-style-type: none"> <li>Licensed registered nurse</li> <li>Licensed practical nurse</li> </ul>	Nurses must have a valid certificate of registration issued by the Board of Nurse Examiners of the State of Montana or the Montana Board of Nursing Education and Nurse Registration.
Mental health services provided by: <ul style="list-style-type: none"> <li>Credentialed school psychologist</li> <li>Licensed psychologist</li> <li>Licensed clinical professional counselor</li> <li>Licensed clinical social worker</li> </ul>	Mental health providers must be licensed according to Montana's state requirements. School psychologist services are provided by a professional with a Class 6 specialist license with a school psychologist endorsement.
Therapy services provided by: <ul style="list-style-type: none"> <li>Licensed occupational therapist</li> <li>Licensed physical therapist</li> <li>Licensed speech language pathologists</li> </ul>	These therapists are required to meet appropriate credentialing requirements as defined by the Montana Licensing Board.
Personal care paraprofessional	No licensing requirements

It is the responsibility of the school district to assure appropriately licensed providers perform all Medicaid covered services. Each school district must maintain documentation of each rendering practitioner's license, certification, registration or credential to practice in Montana. Suspended Medicaid providers may not provide school-based services.

**IEP requirements**

Services provided to Medicaid clients must be covered by Medicaid and documented in the client's Individualized Education Plan (IEP). Medicaid does not cover health-related services that are not included in an IEP unless all of the following requirements are met:

- Youth is enrolled in Medicaid
- Services are medically necessary
- A fee schedule is established for health-related services (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

Services provided to Medicaid clients must be documented in the client's IEP.

- Documentation must not be created retroactively. Providers are responsible for maintaining records at the time of service.

The Montana Medicaid School-Based Services Program is subject to both state and federal audits. As the Medicaid provider, the school certifies that the services being claimed for Medicaid reimbursement are medically necessary and furnished under the provider's direction. Both fiscal and clinical compliance are monitored. In the event of adverse findings, the district/cooperative (not the mental health provider) will be held responsible for any paybacks to Medicaid. If school districts have included a program area for CSCT in their accounting system, then the district can book revenue received from third party insurers or parents that paid privately for CSCT services, providing audit documentation (see the *Comprehensive School and Community Treatment* section in this chapter). To assist in document retention for audit purposes, see the *Audit Preparation Checklist* in *Appendix A: Forms*.

### ***Non-covered services (ARM 37.85.207 and 37.86.3002)***

The following is a list of services not covered by Medicaid.

- A provider's time while attending client care meetings, Individual Educational Plan (IEP) meetings, or client-related meetings with other medical professionals or family members
- A provider's time while completing IEP related paperwork or reports
- CSCT services provided without an individualized treatment plan for this service
- Services considered experimental or investigational
- Services that are educational or instructional in nature
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment.

### ***Importance of fee schedules***

The easiest way to verify coverage for a specific service is to check the Department's school-based services fee schedule. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).



Use the current fee schedule for your provider type to verify coverage for specific services.

## Coverage of Specific Services

The following are coverage rules for specific school-based services.

### ***Assessment to initiate an IEP***

Medicaid covers medical evaluations (assessments) to develop an IEP as long as an IEP is subsequently established and health-related needs are identified.

### ***Comprehensive School and Community Treatment (CSCT)***

Comprehensive School and Community Treatment (CSCT) is a very intense service designed for youth who are in immediate danger of out-of-home placement and/or exclusion from school or community. CSCT provides a comprehensive, planned course of outpatient treatment provided primarily in the school to a child with a serious emotional disturbance. These services are provided through a program operated by a public school district that is a licensed mental health center or a school district that has a contract with a licensed mental health center.

#### **CSCT requirements and approval process**

The CSCT program has a specific program approval process. To be approved, a program must provide the Montana Department of Public Health and Human Services with a satisfactory written description of the program prior to beginning services. For more information on how to apply for program approval, contact the Montana Department of Public Health and Human Services (see *CSCT Program* in *Key Contacts*). For information on CSCT Program requirements, see *Appendix C: CSCT Program*.

- ***Services provided by a Mental Health Center.*** Services under the CSCT program must be provided by a school that is a mental health center or a mental health center that has contracted with the schools. This program requirement has changed from the previous CSCT program when it was run directly by mental health centers. Schools are now required to lead the program management and are specifically required to meet all of the requirements described in this chapter.
- ***Program approved before providing services.*** Program approval must be given to the mental health center prior to the service implementation in order for school districts or cooperatives to implement CSCT programs. See *Appendix C: CSCT Program*.
- ***Program staff requirements.*** Program staff must include at least two mental health workers and one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counselor or pre-licensed professional. The Department of Public Health and Human Services must approve a

The CSCT Program must follow *free care rules* (see *Definitions*).

pre-licensed professional prior to program approval, but approval is not required for licensed providers.

- ***Children must have serious emotional disturbances.*** The CSCT program is intended specifically for children who have serious emotional disturbances, regardless of whether the child is eligible for special education services. This program is not intended for children with functional limitations who require support for activities of daily living (ADL). Children that require ADL support are covered by other Medicaid services like personal care paraprofessionals.
- ***Services must be medically necessary (ARM 37.82.102 and 37.85.410).*** CSCT services must be medically necessary. See *medically necessary* in the *Definitions* section of this manual. Medicaid considers experimental services or services which are generally regarded by the medical profession as unacceptable treatment not medically necessary.
- ***Documentation requirements (ARM 37.85.414).*** The clinical treatment plan for CSCT services paid by Medicaid must demonstrate how the services will address medical necessity. The service provider should maintain documentation that includes:
  - Date of service
  - Time in and time out
  - Who was served
  - Where service occurred
  - Result of service and how the service relates to the treatment plan and goals
  - Who provided the service

This documentation, in addition to serving as documentation of services provided, also provides documentation for billing of CSCT services. In addition to this documentation and any clinical records required by mental health centers license rules, the CSCT program must maintain the following records:

- Documentation of the child's attendance in school and in program services
- Notes for each individual therapy session and other direct services
- Weekly overall progress notes
- ***Services must be available to all qualifying children.*** CSCT services must be made available to all children that meet criteria for those services, not just because the child has Medicaid benefits. In the case of school-based programs that provide services to children

that do not have IEPs, Medicaid will pay for covered services if the following are in place:

- A fee schedule is established (can be a sliding scale to adjust for individuals with low incomes)
- The provider determines if each individual who receives services has insurance coverage or will be billed on a private-pay basis
- The provider bills all individuals and/or the insurance carrier for the medical service provided

The exception to this policy is the services that are provided to Medicaid eligible children and the services are written into the children's IEPs (see *IEP Requirements* in this chapter).

- ***Program must follow free care rule.*** Everyone who receives CSCT services must be billed for the services. If a service is free for non-Medicaid clients, then it is free for all children. Medicaid billable services provided under an IEP are not subject to the *free care rule* (see *IEP Requirements* in this chapter).

### **Services included**

Strategies, coordination and quality improvement activities related to the individual child's treatment plans are included in the CSCT program in addition to the following direct care services:

- Individual, family and group therapy
- Social skills training
- Behavior intervention planning
- Crisis intervention services
- Case management
- School, family and community support

### **Service requirements**

The CSCT program must be provided through a program of services staffed by at least two mental health workers who work exclusively in the school. At least one of the two mental health workers must be a licensed psychologist, licensed clinical social worker, licensed professional counselor, or a DPHHS approved pre-licensed professional. These workers must maintain caseloads not to exceed 12 severely emotionally disturbed (SED) youth.

- *Caseload* refers to the total number of clients enrolled in the CSCT program. It does not refer to a daily or average attendance. Ideally the staff and caseload should be all contained in one school. It is acceptable, however, for a CSCT program with a caseload of no more than 12 and a full-time staff of two to be spread across no more than two school campuses located in close proximity of one

another. Coverage by a CSCT team of more than two school campuses or use of part-time staff are not acceptable.

- The expectation is that the full-time CSCT staff will be available throughout each day to meet the needs of the CSCT clients. It is not generally appropriate, therefore, for the licensed or pre-licensed professional CSCT worker to have an outpatient caseload in addition to CSCT duties. The only exception is youth transitioning out of CSCT who need some therapeutic support. Regardless of the size of the CSCT caseload, the CSCT licensed or pre-licensed professional may carry a caseload of up to 2 youth who have transitioned out of CSCT and need continued therapy as part of the transition.
- The use of a “Pre-Licensed Professional” in a CSCT program is allowed on an infrequent and exceptional basis. It is recognized that recruitment of licensed professionals may be difficult in some parts of the state. Approval for such an arrangement must be obtained from the Department in writing. In its request to use a pre-licensed professional the CSCT program must document the following:
  - The program has advertised for a licensed professional unsuccessfully in newspapers and through Job Service for at least three weeks. The program must have offered a salary that is competitive for the community in which the program is located. The Department will not approve the use of a pre-licensed professional unless a salary of at least state pay plan grade 15, entry level (currently \$31,085 per year) plus benefits including health insurance, has been offered during the unsuccessful recruitment.
  - The pre-licensed professional has completed all academic work required for the license and has begun the post-degree supervised experience required for licensure.
  - A licensed professional has entered into a written agreement to provide supervision of the post degree experience required for licensure.
  - A licensure examination date (or at least an approximate date) has been selected.
  - The pre-licensed professional may serve in lieu of a licensed CSCT staff for no more than 2 years.
  - The pre-licensed professional has had relevant prior experience serving SED children.
  - The CSCT program offers at least one hour of face-to-face supervision by a licensed professional at the CSCT site each week.

- CSCT services must also be available for non-Medicaid clients who meet the CSCT program requirements. In addition to providing these services, districts/cooperatives must also request payment for these services. Services may be billed based on a sliding fee schedule to non-Medicaid children. Schools contract with their CSCT provider to bill private-pay patients and insurance carriers.
- CSCT services not specified in the IEP must be made available and billed to **all** children who receive services.
- Providers may not bill Medicaid for any CSCT services that are generally offered to all clients without charge.
- CSCT services do not require PASSPORT approval or inclusion in the child's IEP.
- CSCT services must be provided according to an individualized treatment plan. The treatment plan must be designed by a licensed professional who is a CSCT staff member.

### **Services restricted**

Medicaid does not cover the following services under the CSCT program:

- Observation and non-face to face service to the client
- More than 80 units of service per calendar month
- The following services are not covered when provided on the same day as CSCT services:
  - Acute or sub-acute partial hospitalization (HCPCS procedure code H0035 with modifiers U6, U7, U8)
  - Youth day treatment (HCPCS procedure code H2012 with modifier HA)
  - Community based psychiatric rehabilitation and support services (HCPCS procedure code H2019 and H2019 with modifier HQ)
  - Outpatient therapy (CPT codes 90804 through 90857 for psychologists, licensed clinical social workers, or licensed clinical professional counselors)

### ***Therapy services***

Therapy includes speech, occupational and physical therapy services. Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the school's supervising licensed therapist's Medicaid provider number (see the *Billing Procedures* chapter in this manual).

**Services included**

Covered therapy services include the following:

- Restorative therapy services when the particular services are reasonable and necessary to the treatment of the client's condition and subsequent improvement of function. The amount and frequency of services provided must be indicated on the client's IEP.
- Assessment services to determine client medical needs and/or to establish an IEP, as long as the assessment results in health-related services documented in the IEP.

**Service requirements**

For clients who are enrolled in the PASSPORT To Health program, the client's PASSPORT provider's approval is required before providing therapy services. For instructions on receiving PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

**Services restricted**

- Montana Medicaid does not cover therapy services that are intended to maintain a client's current condition but only covers services to improve client functions.
- Therapy services are limited to 40 hours per state fiscal year (July 1 - June 30) for each type of therapy. This limit may be exceeded if the client is still progressing in his or her treatment.

***Private duty nursing services***

Private duty nursing services are skilled nursing services provided by a registered or licensed practical nurse.

**Service requirements**

Medicaid covers private duty nursing services when all of the following requirements are met:

- When the client's attending physician or mid-level practitioner orders these services in writing
- When the client's PASSPORT provider or primary care provider approves the service (see the *PASSPORT and Prior Authorization* chapter in this manual)
- When prior authorization (PA) is obtained (see the *PASSPORT and Prior Authorization* chapter in this manual for PA requirements)

***School psychologists and mental health services***

Psychological services in schools are based on determining eligibility for inclusion in special education programming and not necessarily to determine a medical diagnosis outside of the guidelines of the Individuals with Disabilities Education Act.

**Services included**

Psychological and mental health services include the following:

- Individual psychological therapy
- Psychological tests and other assessment procedures when the assessment results in health-related services being written into the IEP
- Interpreting assessment results
- Obtaining, integrating and interpreting information about child behavior and conditions as it affects learning, if it results in an IEP. This only includes direct face-to-face service.
- Mental health and counseling services that are documented on the client's IEP
- Consultation with the child's parent as part of the child's treatment

**Service requirements**

Medicaid covers psychological counseling services when the following two criteria are met:

- The client's IEP includes a behavior management plan that documents the need for the services
- A CSCT service is not provided to the client on the same day

**Services restricted**

Montana Medicaid does not cover the following psychological services:

- Testing for educational purposes
- Psychological evaluation, if provided to a child when an IEP is not subsequently established
- Review of educational records
- Classroom observation
- Scoring tests

***Personal care paraprofessional services***

Personal care paraprofessional services are medically necessary in-school services provided to clients whose health conditions cause them to be limited in performing activities of daily living. That is, these services are provided for clients with functional limitations.

**Services included**

These activities of daily living services include:

- Dressing
- Eating
- Escorting on bus

Personal care services are not covered when provided by an immediate family member.

- Exercising (ROM)
- Grooming
- Toileting
- Transferring
- Walking

### **Service requirements**

- These services must be listed on the client's IEP.
- Approval must be given by the client's PASSPORT provider or primary care provider prior to billing for Medicaid covered services. For instructions on obtaining PASSPORT approval, see the *PASSPORT and Prior Authorization* chapter in this manual.

### **Services restricted**

Medicaid does not cover the following services provided by a personal care paraprofessional:

- Skilled care services that require professional medical personnel
- Instruction, tutoring or guidance in academics
- Behavioral management

Please see *Appendix B: Personal Care Paraprofessional Services Documentation*, which includes the child profile and service delivery record. The child profile provides detailed examples of activities of daily living.

### ***Special needs transportation***

Special needs transportation includes transportation services for clients with special needs that are outside of traditional transportation services provided for clients without disabilities.

### **Services include**

Special needs transportation services are covered when all of the following criteria are met:

- Transportation is provided to and/or from a Medicaid-covered service on the day the service was provided
- The Medicaid-covered service is included in the client's IEP
- The need for special needs transportation service is included in the client's IEP

Specialized transportation services are covered if one of the following conditions exists:

- The medical need for specialized transportation is identified in the IEP



The school district must maintain documentation of each service provided, which may take the form of a trip log.

- A client requires transportation in a vehicle adapted to service the needs of students with disabilities, including a specially adapted school bus
- A client resides in an area that does not have school bus transportation (such as those in close proximity to a school).
- The school incurs the expense of the service regardless of the type of transportation rendered

### **Services included**

Special needs transportation includes the following:

- Transportation from the client's place of residence to school (where the client receives health-related services covered by the Montana School-based Services program, provided by school), and/or return to the residence.
- Transportation from the school to a medical provider's office who has a contract with the school to provide health-related services covered by the Montana School-based Services program, and return to school.

### **Services restricted**

Clients with special education needs who ride the regular school bus to school with other non-disabled children in most cases will not have a medical need for transportation services and will not have transportation listed in their IEP. In this case, the bus ride should not be billed to the Montana School-based Services program. The fact that clients may receive a medical service on a given day does not necessarily mean that special transportation also would be reimbursed for that day.

### ***Authorization requirements summary***

The following table is a summary of authorization requirements for school-based services that were described in each section above. For more information on how to obtain prior authorization and PASSPORT provider approval, see the *PASSPORT and Prior Authorization* chapter in this manual.



Medicaid does not cover special transportation services on a day that the client does not receive a Medicaid-covered service that is written into the IEP.

<b>Authorization Requirements</b>			
<b>Service</b>	<b>Prior Authorization</b>	<b>PASSPORT Provider Approval</b>	<b>Written Physician Order/Referral</b>
<b>CSCT services</b>	No	No	No
<b>Therapy services</b>	No	Yes	No
<b>Private duty nursing services</b>	Yes	Yes	Yes
<b>School psychologist and mental health services</b>	No	No	No
<b>Personal care paraprofessional services</b>	No	Yes, if applicable (If the client is enrolled in PASSPORT, PASS-PORT provider approval is required.)	Yes, if applicable (If the client is not enrolled in PASS-PORT, the client's primary care provider must provide a written order/referral.)

## Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

***Mental Health Services Plan (MHSP)***

The school-based services in this manual are not covered benefits of the Mental Health Services Plan (MHSP). However, the mental health services in this chapter are covered benefits for Medicaid clients. For more information on the MHSP program, see the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

***Children's Health Insurance Plan (CHIP)***

The school-based services in this manual are not covered benefits of the Children's Health Insurance Plan (CHIP). Additional information regarding CHIP benefits is available by contacting BlueCross BlueShield at 1-800-447-7828 ext. 8647.

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*). When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the services before billing Medicaid for the services.

## Service Fees

The Office of Management and Budget (OMB A-87) federal regulation specifies one government entity may not bill another government entity more than their cost. Schools should bill Medicaid their cost of providing a service, not the fee published by Medicaid for the service. The Medicaid fee schedule is to inform provider of the maximum fee Medicaid pays for each procedure.

## Coding Tips

Effective January 1, 2004, the procedure codes listed in the following table will be the only valid procedures for schools to use for billing Medicaid. Although schools may continue to utilize the procedure codes published in the July 2003 fee schedule until that time, it is recommended that providers use only the following procedure codes.



Any codes billed by schools on or after January 1, 2004 that are not listed in the following table, will be denied.

<b>School-Based Services Codes</b>		
<b>Service</b>	<b>CPT Code</b>	<b>Unit Measurement</b>
<b>Occupational Therapist</b>		
Occupational therapy – individual therapeutic activities	97530	15 minute unit
Occupational therapy – group therapeutic procedures	97150	Per visit
Occupational therapy evaluation and re-evaluation	97003	Per visit
<b>Physical Therapist</b>		
Physical therapy – individual therapeutic activities	97530	15 minute unit
Physical therapy – group therapeutic procedures	97150	Per visit
Physical therapy evaluation and re-evaluation	97001	Per visit
<b>Speech Therapists</b>		
Speech/hearing therapy – individual	92507	Per visit
Speech/hearing therapy – group	92508	Per visit
Speech/hearing evaluation	92506	Per visit
<b>Private Duty Nursing</b>		
Private duty nursing services provided in school	T1000	15 minute unit
<b>School Psychologist/Mental Health Services</b>		
Psychological therapy – individual	90804	Per 30 minute unit
Psychological therapy – group	90853	Per visit
Psychological evaluation	96100	Per hour
<b>CSCT Program</b>		
CSCT services – individual	H0036	15 minute unit
<b>Personal Care Paraprofessionals</b>		
Personal care services	T1019	15 minute unit
<b>Special Needs Transportation</b>		
Special needs transportation	T2003	Per one-way trip

### ***Using modifiers***

School-based services providers only use modifiers for coding when the service provided to a client is not typical. The modifiers are used in addition to the CPT codes. The following modifiers are typically used in schools:

- Modifier “52” is billed with the procedure code when a service is reduced from what the customary service normally entails. For example, a service was not completed in its entirety as a result of extenuating circumstances or the well being of the individual was threatened.
- Modifier “22” is billed with the procedure code when a service is greater than the customary service normally entails. For example,

### ***Comprehensive School and Community Treatment (CSCT)***

If a provider spent 30 minutes in social skills training with a Medicaid client, it would be billed like this (the unit measurement for this code is 15 minutes):

A									B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE									Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS     MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
From	MM	DD	YY	MM	DD	YY	To	YY										
11	05	03	11	05	03	03	0			H0036		2		\$ 40:00	2			

The CSCT program must follow the free care rule. That is, if it is free for non-Medicaid children, then it is free for all children.

### ***Therapy services***

Services may be performed by a therapy assistant or therapy aide but must be billed to Medicaid under the supervising licensed therapist's Medicaid provider number. Remember to include the client's PASSPORT provider's PASSPORT approval number in field 17a of the claim form (see the *Completing a Claim* chapter in this manual). Thirty minutes of individual physical therapy would be billed like this (the unit measurement for this code is "15 minute unit"):

24. A										B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE										Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD	YY	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
12	02	03	12	02	03	03	0				97530			1	\$ 40:00	2				

### ***Private duty nursing services***

Both PASSPORT and prior authorization are required for these services, so remember to include the PASSPORT provider's PASSPORT number in field 17a and the prior authorization number in field 23 of the CMS-1500 claim form (see the *Completing a Claim* chapter in this manual). Private duty nursing services provided for 15 minutes would be billed like this:

24. A						B	C		D		E	F	G	H	I	J	K
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE	
MM	DD	YY	MM	DD	YY	03	0	CPT/HCPCS	MODIFIER								
09	02	03	09	02	03	03	0	T1000			1	\$ 5:00	1				

### ***School psychologists and mental health services***

A psychological therapy session of 30 minutes would be billed like this (the unit measurement for this code is "per 30 minute unit"):

24.	A DATE(S) OF SERVICE						B	C	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E	F	G	H	I	J	K
	From	MM	DD	YY	To	MM	DD	YY	Place of Service	Type of Service		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	09	02	03	09	02	03	03	0			90804	1	\$ 50:00	1				

### ***Personal care paraprofessional services***

Remember to include the client's PASSPORT provider number in field 17a of the CMS-1500 claim form (see the *Completing a Claim* chapter in this manual). Personal care services provided to a client for 2 hours during a day would be billed like this (the unit measurement for this code is per 15 minute unit):

24.	A DATE(S) OF SERVICE						B	C	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E	F	G	H	I	J	K
	From	MM	DD	YY	To	MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	09	02	03	09	02	03	03	0			T1019	1	\$ 24:00	8				



The CSCT program must follow the "free care" rule.

***Special needs transportation***

School districts must maintain documentation of each service provided, which may take the form of a trip log. Schools must bill only for services that were provided. Special transportation should be billed on a per one-way trip basis. For example, if a client was transported from his or her residence to school to receive Medicaid covered health-related services, and then transported back to his or her residence, it would be billed like this:

24.	A DATE(S) OF SERVICE						B	C	D		E	F	G	H	I	J	K
	From To						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
	09	02	03	09	02	03	03	0	T2003		1	\$ 20.00	2				

**Submitting a Claim*****Paper claims***

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing  
P.O. Box 8000  
Helena, MT 59604

***Electronic claims***

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ACS field software WINASAP 2003. ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- ACS clearinghouse. Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- Clearinghouse. Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

For more information on electronic claims submission, contact Provider Relations or ACS EDI Gateway (see *Key Contacts*).

## Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

## The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a <b>7-digit</b> number assigned to the provider during Medicaid enrollment. Verify the correct <b>Medicaid</b> provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information For Providers</i> manual. Medicaid eligibility may change monthly.

### Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. PASSPORT approval is different from prior authorization. See the <i>PASSPORT and Prior Authorization</i> chapter in this manual.
Prior authorization number is missing	<ul style="list-style-type: none"> <li>• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Prior authorization is different from PASSPORT authorization. See the <i>PASSPORT and Prior Authorization</i> chapter in this manual.</li> </ul>
Prior authorization does not match current information	<ul style="list-style-type: none"> <li>• Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.</li> </ul>
Duplicate claim	<ul style="list-style-type: none"> <li>• Please check all remittance advices (RAs) for previously submitted claims before resubmitting.</li> <li>• When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see <i>Remittance Advices and Adjustments</i> in this manual).</li> </ul>
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> <li>• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual.</li> <li>• If the client's TPL coverage has changed, providers must notify the TPL unit (see <i>Key Contacts</i>) before submitting a claim.</li> </ul>
Claim past 12-month filing limit	<ul style="list-style-type: none"> <li>• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter.</li> <li>• To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.</li> </ul>
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	<ul style="list-style-type: none"> <li>• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment.</li> <li>• New providers cannot bill for services provided before Medicaid enrollment begins.</li> <li>• If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.</li> </ul>
Procedure is not allowed for provider type	<ul style="list-style-type: none"> <li>• Provider is not allowed to perform the service.</li> <li>• Verify the procedure code is correct using current HCPCS and CPT-4 billing manual.</li> <li>• Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.</li> </ul>

# How Payment Is Calculated

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## Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims. The payment methods described do not apply to services provided under the Children's Health Insurance Program (CHIP).

## Certification of State Match

A state certification of match process allows the state to leverage public education dollars to draw down federal funds. The state of Montana has implemented a state certification of match process for purposes of drawing down Federal Medical Assistance Percentage (FMAP) for the school based fee-for-service program. The FMAP rate fluctuates each year and will be reflected in reimbursements to schools. DPHHS is working in conjunction with the Office of Public Instruction (OPI) in the certification of match process for Medicaid covered school-based health-related services. This process includes all direct services billed to Medicaid under the School-based Health Services program including CSCT services that are written into an IEP.

### ***CSCT services included in IEP***

If CSCT services are included on a child's IEP, then the school district/cooperative does not need to do anything else to certify match for federal funds to be drawn down. Health services that are part of the Medicaid School-based Health Services program and are included on the IEP are covered by OPI's certification of match procedure that is based on the trustees' financial summary report utilizing special education expenditures that are documented and maintained at the state level. This greatly simplifies the process for matching federal funds.

### ***CSCT services not included in IEP***

The CSCT program, like all other services that are included in the Medicaid School-based Health Services program require certification of the use of local and state funds to match the state portion of the Medicaid funds. Because services are provided to children who do not have an IEP there is a requirement that schools who administer the CSCT program verify that the district has sufficient state and local funds to support the CSCT program in order to draw down the federal funds for children that are receiving CSCT services that are not included on an IEP. This match is required on an annual basis to DPHHS.

This match must come from non-federal sources. State special education funds and federal funds cannot be used for purposes of this match. The following formula will assist district in calculating the district's match obligation:

Medicaid payment for CSCT Services / Current FMAP Rate X Current State Match Rate = Local District Match

The annual certification of match will be due at the end of December of each year. Conservatively, CSCT services may be reimbursed by federal Medicaid funds upwards of \$200,000 per school year per program. This means that a school could have to certify they had \$63,260 of expenditures to cover the district costs associated with these CSCT services. Insufficient match will result in a payback.

*Appendix C: CSCT has a Sample Certification of Match Statement, which shows a sample of the document that the school district/cooperative will receive annually for DPHHS that shows the amount of money that has been expended on CSCT services and the required state and local funds that must be certified for the federal match. The school district/cooperative must certify, by signing the document, that sufficient state and local expenditures (the amount listed in item 3 of the Sample Certification of Match Statement) have been used to support this program. The Certification of Match Statement must be returned to DPHHS. If the school district/cooperative have provided CSCT services to clients as part of the IEP, please contact DPHHS to obtain a breakdown by client to calculate reimbursement for services that were not included on IEPs for matching purposes.*

For audit purposes, the district must maintain documentation that validates that local and state dollars were spent. This documentation does not necessarily have to show the exact funds that are certified but must demonstrate that sufficient state and local funds were spent (and that these funds were not used as certification of federal match elsewhere).

***Requirements for matching expenditures***

- The matching funds can include both direct and indirect expenses.
- The matching funds can include expenses that were paid by state and local dollars.

***Restrictions for matching expenditures***

- Matching funds for this program cannot include federal dollars like:
  - IDEA funds
  - Medicaid reimbursement

***How to document expenditures used to certify match***

Each school district or cooperative can document these funds in a variety of ways. The key is to be able to identify that sufficient state and local funds were available to use for federal match. Districts can:

- Develop a program code within the accounting system to capture expenditures for the CSCT program costs.
- Develop work papers that verify which dollars of local and state expenditures were used for matching.

**Payment for School-Based Services**

Federal regulations specify that one government entity may not bill another government entity more than their cost (OMB A-87). The following describes payment methods for various services that can be provided in the school setting. Payment for these services is limited to the lower of the calculated fee or the billed amount.

***Speech, occupational and physical therapy services***

Speech and language therapy services, occupational therapy services and physical therapy services are paid by the RBRVS method of reimbursement. RBRVS stands for Resource Based Relative Value Scale. These services are paid 90% of the RBRVS office fee paid to physicians for the same service. As noted above, only the federal portion will be paid. For more detail on the RBRVS system, see the *How Payment Is Calculated* chapter of the *Physician Related Services* provider manual, which is available on the Provider Information website (see *Key Contacts*).

The following illustrates how RBRVS payments are calculated for therapy services. Examples are for illustration only. The numerical examples are from July 2003 and may not apply at other times.

Each RBRVS fee is the product of a relative value times a conversion factor, multiplied by 90%. For example, the fee for a physical therapy evaluation (CPT code 97001) is:

1.825 relative weight x conversion factor of \$31.18 x 90% = \$51.21 per visit

The federal portion of this fee is  $\$51.21 \times .7591 = \$38.87$  per visit

The fee for a therapeutic activities (OT) code (CPT code 97530) is:  
 $.704$  relative weight x conversion factor of  $\$31.18 \times 90\% = \$19.75$  per 15 minute unit

The federal portion of this fee is  $\$19.75 \times .7591 = \$14.99$  per 15 minute unit

The Department publishes relative weights and the current conversion factor. The conversion factor is determined by the Department, and set at a level intended to achieve legislatively set budget targets.

### ***Private duty nursing***

The only code available for this service is T1000. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15 minute units = payment

For 30 minutes of service:

$\$5.25 \times 2 = \$10.50$  for two 15 minute units

The federal portion of this payment is  $\$10.50 \times .7591 = \$7.97$  for two 15 minute units

### ***School psychologist***

Both codes available for billing school psychologist services are paid by the RBRVS method.

The following illustrates how RBRVS payments are calculated. Examples are for illustration only. The numerical examples are from July 2003 and may not apply at other times.

Each RBRVS fee is the product of a relative value times a conversion factor, multiplied by 90%. For example, the fee for psychological therapy (CPT code 90804) is:

$1.618$  relative weight x conversion factor of  $\$31.18 \times 90\% = \$49.95$  per 30 minute unit

The federal portion of this payment is  $\$49.95 \times .7591 = \$37.91$

The Department publishes relative weights and the current conversion factor. The conversion factor is determined by the Department, and set at a level intended to achieve legislatively set budget targets.

***Personal care paraprofessionals***

The only code available for this service is T1019. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15 minute units x 90% = payment

$\$3.45 \times 2 \times 90\% = \$ 6.21$  for two 15 minute units

The federal portion of this payment is  $\$6.21 \times .7591 = \$ 5.58$

***CSCT Program***

The only code available for this service is H0036. Payment for this code is based on the Medicaid fee schedule, and is calculated as follows:

Fee x number of 15 minute units x 90% = payment

$\$24.46 \times 2 \times 90\% = \$ 44.02$  for two 15 minute units

The federal portion of this payment is  $\$ 44.02 \times .7591 = \$33.41$

All payments for CSCT services are made to the school district/cooperative. Schools may not assign payment from Medicaid directly to the mental health center provider. The purpose of this policy is to:

- Ensure that districts are fully aware of the amount of Federal Medicaid funds generated by their CSCT providers, allowing districts to determine their obligation for match.
- Control variables are in place to account for districts revenue and expenditures.

***How payment is calculated on TPL claims***

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as Third Party Liability or TPL. In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

***How payment is calculated on Medicare crossover claims***

When a client has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the co-insurance and deductible amounts for these dually eligible individuals. See the *How Payment is Calculated* chapter in the *Physician Related Services* manual for examples on how payment is calculated on Medicare crossover claims.



## **Appendix C: CSCT Program**

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- *CSCT Program Approval Requirements*
- *Sample Certification of Match Statement*

### ***CSCT Program Approval Requirements***

Prior to CSCT program implementation, the Department of Public Health and Human Services must approve the program. The following documentation is required as part of the approval process:

1. CSCT program description
2. Completed CSCT Program Form
3. Copy of school contracts with CSCT provider
4. Identified mental health center contact person per agency (not per program)

Allow 30 days for processing. To certify additional CSCT programs, complete another CSCT Program Form and copy the school contract.

### ***Program Manual***

The program manual must include the following:

1. How the program will meet each child's needs for treatment during and outside school hours, including:
  - a. Individual, family and group therapy
  - b. Crisis intervention
  - c. Case management
  - d. Continuing observation, support and behavioral intervention in the classroom and on the playground
  - e. Other services effective in the treatment of the child's emotional disturbance
2. How the program will meet each child's needs for treatment during school vacations in a manner integrated in the individual's treatment plan.
3. Limited circumstances that would require a child in the program to access mental health services outside the program and how the program would minimize reliance on other service providers.
4. Admission and discharge criteria for the program.
5. How the program will accomplish and ensure:
  - a. Treatment, crisis and discharge planning and regular updates of such plans.
  - b. Family involvement in treatment and discharge planning and in the course of treatment.
  - c. Continuing contact and information exchange with persons and agencies significantly involved in the child's treatment.
  - d. Coordination of all mental health services and treatments the child receives.
  - e. Continuing quality improvement including the regular measurement and reporting of program performance and individual outcomes to include comparison with baseline measurements and established benchmarks.
  - f. That a sliding fee schedule and all available financial resources for support of services including third party insurance and parent payment are utilized.
  - g. There is an appropriate level of direct contributions by the school district.
  - h. That services delivered are adequately documented to support the reimbursement received.

## ***Sample Certification of Match Statement***

This statement is provided annually by DPHHS and must be returned to verify certification of local and state expenditures to support the federal match.

Montana Department of Public Health and Human Services  
Medicaid Services Bureau  
P.O. Box 202951  
Helena, MT 59620 - 2951

RE: Annual Certification of State and Local Expenditures

Dear \_\_\_\_\_:

I, as financial officer of the \_\_\_\_\_ School District/Cooperative, am charged with the duties of supervising the administration of the provision and billing for the Comprehensive School and Community Treatment (CSCT) Services provided under Title XIX (Medicaid) of the Social Security Act, as amended. I hereby certify that the school district has expended the state and local share of public, non-federal funds needed to match the federal share of medical claims billed to the state Medicaid agency for School District CSCT services provided to eligible children during the \_\_\_\_\_ school year.

1. DPHHS has completed calculation of reimbursement for CSCT services for the year \_\_\_\_\_.
2. The amount paid by DPHHS for CSCT services is \_\_\_\_\_.
3. The state and local expenditures that are required to support a certification of match is, \_\_\_\_\_. (Medicaid payment for CSCT Services / Current FMAP Rate X Current State Match Rate = Local District Match)

\_\_\_\_ These certified expenditures are separately identified and supported in our accounting system, or  
\_\_\_\_ Sufficient State and local revenues are available to meet or exceed the match.

I certify that the school district/cooperative's state and local expenditures (shown in # 3 above) were incurred in accordance with provisions of Montana's policies. These certified expenditures are separately identified and supported in our accounting system.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

School District or Cooperative: \_\_\_\_\_

Date: \_\_\_\_\_



### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

### **Electronic Funds Transfer (EFT)**

Payment of medical claims that are deposited directly to the provider's bank account.

### **Emergency Services**

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

### **Experimental**

A non-covered item or service that researchers are studying to investigate how it affects health.

### **Explanation of Benefits Codes (EOB)**

A three digit code which prints on Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the EOB codes is found at the end of the RA.

### **Explanation of Medicare Benefits (EOMB)**

A notice sent to providers informing them of the services which have been paid by Medicare.

### **Fiscal Agent**

ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

### **Free Care Rule**

If a service is free to non-Medicaid clients, then it must also be free to Medicaid clients. Medicaid cannot be billed for services that are provided free to non-Medicaid clients.

### **Full Medicaid**

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

### **Gross Adjustment**

A lump sum debit or credit that is not claim specific made to a provider.

### **HCPCS**

Acronym for the Healthcare Common Procedure Coding System, and is pronounced "hick-picks." There are three types of HCPCS codes:

- Level 1 includes the CPT-4 codes.
- Level 2 includes the alphanumeric codes A - V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT-4 coding.
- Level 3 includes the alphanumeric codes W - Z which are assigned for use by state agencies (also known as local codes).

### **Health Insurance Portability and Accountability Act (HIPAA)**

A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

### **ICD-9-CM**

*The International Classification of Diseases, 9th Revision, Clinical Modification.* This is a three volume set of books which contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

**Indian Health Service (IHS)**

IHS provides health services to American Indians and Alaska Natives.

**Individual Adjustment**

A request for a correction to a specific paid claim.

**Internal Control Number (ICN)**

The unique number assigned to each claim transaction that is used for tracking.

**Investigational**

A non-covered item or service that researchers are studying to investigate how it affects health.

**Kiosk**

A “room” or area in the Montana Virtual Human Services Pavilion (VHSP) website that contains information on the topic specified.

**Mass Adjustment**

Request for a correction to a group of claims meeting specific defined criteria.

**Medicaid**

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

**Medicaid Eligibility and Payment System (MEPS)**

A computer system by which providers may access a client’s eligibility, demographic, and claim status history information via the internet.

**Medically Necessary**

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, “course of treatment” may include mere observation or, when appropriate, no treatment at all.

**Medicare**

The federal health insurance program for certain aged or disabled clients.

**Mental Health Services Plan (MHSP)**

This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

**Mentally Incompetent**

According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

**Montana Breast and Cervical Cancer Treatment Program**

This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

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